Session-Intersession Sequences in the Treatment of Chronic Anorexic-Bulimic Patients: Following the Model of "Family Games"

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In this article, the author presents some technical aspects of a psychotherapeutic approach for treating chronic anorectic patients. Two basic principles underlie the approach. First, the main purpose of the treatment is to improve the patient's relational skills in order to enable her to cope with her family's "game." Second, the therapeutic relationship is considered hierarchically subordinate to her relationships outside the therapeutic context. Mastering the model of families with anorectics is essential if the therapists is to be consistent with these principles. Specialized training in verbal and nonverbal communication is considered a useful tool.

Selvini-Palazzoli and her colleagues (3) have recently proposed a model for the anorectic process in the family. This model is based on the analysis of case data taken from 142 families. Anorexia is considered to be the result of a process occurring over time and affecting the relational organization of these families, the course of which has to be retraced step by step. According to this model, each family member is supposed to play a "covert game," an interactive game in which the participants hide and disguise their feelings, goals, and intentions from each other. An important strategy in this model is the "imbroglio," that holding a transgenerational dyadic relationship to be privileged when it is nothing of the sort.

If the parents' relationship is selected as an (arbitrary) point of departure for a brief explanation, the whole process can be divided into the following six stages:

1. Each parent provocatively demands a change in the other's behavior while blocking the other's demands (couple stalemate). Individual demands are never made on the basis of personal needs but, rather, as appeals to the husband's or wife's duty as a father/mother, on behalf of the children, and so on.

2. At a very early age, the anorecticto-be starts getting involved in the parental relationship. Most often she's totally devoted to her mother, helps her with the housework, listens to her complaints; she tends to espouse her mother's relational viewpoints¾although she doesn't really respect her. Sometimes, instead, it is the father-daughter relationship that appears to be the privileged one at this early age.

3. During adolescence, the future anorectic turns to the father¾often because she realizes that her mother's interest has shifted to a sibling. She believes she shares her father's contempt for this insincere and narrow-minded woman (mutual instigation against the mother). Both of them have to put up with her just to keep the peace in the family.

4. Neglected by her mother and encouraged by her father, the girl needs to distinguish herself from her mother; she loathes the idea of resembling her in any way, and changes her own habits accordingly. Her diet, in the beginning, often has this meaning. The mother tries to control these eating habits, unwittingly reinforcing them.

5. Against the girl's expectations and hopes, the father doesn't openly side with her against his wife, although he obviously disapproves of her (father's volte-face).

6. Once the symptom is established, the patient realizes that the power it gives her allows her to recapture the illusory status she enjoyed during childhood. On the other hand, each member of the

family possibly realizes he or she can use the patient's illness to influence the behavior of other family members.

Selvini-Palazzoli and Viaro (4) have suggested the possibility of using this same model as a guideline for individual psychotherapy in the treatment of chronic anorectic patients. In chronic anorexia nervosa, family therapy is often not possible, not useful, or not advisable.

In individual treatment, the therapist and the patient draw up the following contract: the aim of therapy is to help the patient improve her relationships with others, especially her family. Consequently, her relationship with the therapist, in order to be instrumental, must be hierarchically subordinate to all other relationships. The treatment does not call for either drug therapy or the therapist's consultation with third parties. Consequently, the success of the therapy depends on the information exchanged in the sessions and on the way the patient uses this information in her relationships with others. Clearly, the therapist has direct control over the former but not the latter.

The reconstruction of how the patient uses the information provided in therapy in her relationships with her family and others constitutes one of the main technical problems of therapy and is the subject os this article.

TECHNICAL ASPECTS OF INDIVIDUAL TREATMENT

Conducting the Session

A clinical example may be useful. It is taken from Anna's third therapy session. Anna is a patient who had been suffering from anorexia-bulimia for about 10 years. The weekly sessions were held on Thursdays. The second session was largely dedicated to trying to reconstruct Anna's clinical history, which she said she had difficulty recalling. On the Sunday following this session, Anna, who lives alone, was invited to have lunch at her parents' home, where her younger sister still lives. During the lunch, Anna asks them to help her recollect. She said that the therapist had asked her if anything particular happened to her or her family right before the onset of her symptoms 10 years earlier. anna mentions an episode: at one time, she said, her mother had been completely against her going out with a classmate who was courting her. Anna, however, didn't remember the details very well, nor exactly when this happened. Her father also vaguely recalled the incident, but could not place it in the correct time frame. Her mother said nothing.

The following morning, Monday, Anna received a telephone call from her mother who had hardly slept the night before, trying to search her memory for an answer to Anna's question. Finally, she had come up with something. Because Anna was constantly preoccupied with being the best student in her class, she had studied very hard for her exams during her senior year in high school and, as a result, had totally worn herself out. Immediately after her exams, she began to lose weight conspicuously.

On Wednesday, two days after this telephone call, Anna called her father at his office and asked him to meet her briefly for lunch. The father agreed. During their short encounter, her father, who seemed quite upset, brought up the subject again. He said he had made a mistake on Sunday at lunch and now backed up his wife's version. That very night, Anna bought an enormous amount of food, on which she binged and promptly vomited.

The next day, Thursday, at the beginning of the third session, she appeared depressed. She said she had lost faith in the therapy. She feels so bad whenever she has to talk about herself and her past that she had been through a terrible week and, not being able to resist temptation, had been on a binge the night before. The therapist and patient's reconstruction of these events took place during

the entire third session. At the beginning of the session, Anna simply stated that she was feeling worse because in their last session the therapist had inquired into her past.

The process of reconstructing events is based on a premise, namely, that therapy consists essentially of an exchange of information between the therapist and the patient, whereas the interpretation and the (hopefully) therapeutic effects of this exchange of information occurs in a much wider context outside a therapeutic setting and includes other people (especially the family). From now on, I refer to the interactive sequence in which the information is used and interpreted as the therapeutic sequence. The reconstruction of the therapeutic sequence may be easier if one follows a few basic steps.

Step 1: Determining Ending and Starting Points

The beginning of every session represents the ending point of a therapeutic sequence: the way a patient enters the office, her attitude, attire, make-up, what she says, how she says it. The differences, even if minimal, with respect to the previous session, represent the week's mood balance. If the patient, in her dealings with other people, has used any of the information she learned during the previous session and if, as a result, she has benefited, she will come in with a positive attitude toward her therapist and the therapy.

In the third session, Anna began by saying she was feeling worse and that she had lost faith. She also looked more depressed than during the previous session. The therapist began the session with a basic working hypothesis; he assumed that the last therapeutic sequence had ended with a negative mood balance.

To determine the starting point of the sequence is more difficult for at least four reasons. First, the therapist may not remember everything that took place during the previous session. Second, what the therapist considers an important point may have been regarded as irrelevant by the patient, who may have chosen to assign more importance to marginal considerations. Third, the patient may have misunderstood or distorted what the therapist had said. Fourth, it is always possible that the patient's attitude at the beginning of any session had little or nothing to do with the therapy and, instead, was due to unrelated events.

In our example, it is Anna who offers the information that she has been feeling worse since the last session. In order to determine what specific information affected her, the therapist must have noted down carefully and in detail everything that was talked about in the previous session, and re-read these notes immediately before the new session. Every single point discussed in the previous session is potentially a starting point for the next therapeutic sequence.

Step 2: Reconstructing the Middle

The middle part of the sequence is the sum of the past week's interactions between the patient and her family members that are in any way related to what the patient and therapist discussed during the previous session. During these exchanges, the patient will most likely have used some of the information gleaned in her last session. Because these interactions take place during the week, the therapist obviously has not been privy to the middle part of the sequence. The reconstruction of these exchanges depends on how well the patient relates the events. Thus, the second part of each session, after the opening, is dedicated to a report of last week's events. Whereas at the beginning of a session the therapist assumes a passive stance and allows the patient to do all the talking, the report consists of an exchange of questions and answers.

In our example, after the patient had been speaking for a few minutes, the therapist remarked that she seemed more depressed and let down than the week before and asked on what day her mood changed. Anna answered: "At the beginning of the week, two or three days ago." The therapist then asked whether her mood had prevented her from going out or seeing people, and if she had done so before her mood worsened. Anna said that all week she'd worked during the daytime and in the evenings stayed home. She visited a friend on two occasions, Friday and Sunday evening. She had lunch at her parents' home on Sunday, however.

The therapist then asked whether her younger sister was present and Anna answered: "No. Otherwise I wouldn't have gone. Luckily, I haven't seen or talked to her all week long. Probably," she added, "I've been feeling low because when I'm at my parents' I feel I have to eat more than I really want, just to please them." The therapist then asked for details about the lunch and what they talked about. Anna said her parents were anxious to learn what her impressions were about the new therapy. This was when she had asked their help in recalling what had happened 10 years ago, asking them the same question the therapist had put to her.

The therapist thus learns about the father and mother's reactions and about the mother's telephone call on Monday morning. The therapist asked why, if she says she is feeling bad because she felt obliged to force down a lot of food at Sunday's lunch, she didn't vomit it up that same evening and chose, instead, to call up a friend. He remarked that she also didn't vomit after her mother's telephone call on Monday, the day she started to feel depressed. Was she sure that she hadn't talked to her parents on either Tuesday or Wednesday evening? At this point, Anna remembered that she saw her father briefly on Wednesday, and told the therapist what they talked about.

By now the therapist has determined both the starting point and the middle part of the therapeutic sequence, and quite precisely: the question he put to Anna in their second session about events 10 years back that led to the onset of symptoms; Anna's answer, "I can't remember very well"; Anna's posing the same question to her parents, with the added allusion to her mother's interference in her first love relationship; her father's cautious agreement and her mother's silence; her mother's phone call on Monday; Anna's change of mood on that same Monday; Anna's inviting her father to lunch with her on Wednesday, and her binging that same evening; her assertion that she was losing faith in the therapy ("I feel bad when I have to talk about myself") at the beginning of the third session.

Step 3: The Concealed Part of the Sequence

The concealed part of the therapeutic sequence is made up of all direct exchanges between family members that take place in the patient's absence and therefore remain unknown both to her and the therapist. In our example, the concealed part of the sequence includes all the exchanges between Anna's parents from Sunday to Wednesday regarding her question about the origins of her anorexia.

After having reconstructed the middle part of the sequence, the therapist asked Anna why, in her opinion, her father retracted on Wednesday what he had said on Sunday. Did she think he may have been influenced by something her mother told him in the meantime? Anna replied that her mother probably kept pestering her father, even keeping him awake at night, until he had no choice but to tell her she was right. Her mother has always been like that. Even when Anna was still living at home, she could hear her parents arguing for hours late into the night, and by the following day, her father had changed his position to fit his wife's. Dad is a very nice man, but weak. To maintain peace in the family, he ends up giving in to his wife even when he doesn't agree with her at all. At home, mom has always had her own way.

The patient's speculations on the concealed part of the sequence clearly reflect what she thinks is the relationship between the other family members. Such conjectures cannot be thought of as grounded in fantasy, but are inferences she draws from the information available to her. The therapist knows, based on his experience in working with parents of anorectic patients, that they are often given to spending much time discussing the patient in her absence. Based on his experience, he also knows that, in these families, the patient often holds a distorted view of her parents' relationship, partly because she is systematically fed misinformation.

The End of the Session

In the last part of each session, the therapist explicitly states his reconstruction of the sequence; he spells out which information from the previous session the patient used in her interactions with her family, how she used it, how her family reacted, and the possible significance of these reactions; finally, he draws a connection between her mood at the beginning of the session and the events of the past week.

In our example, the therapist says that, in his opinion, the patient has used the question he put to her about the onset of her symptoms in an unsuccessful move to oblige her father to side openly with her against her mother, and that the reason she feels depressed and let down is because her father did an about-face on her. Her veiled accusation of her mother as meddling in her first adolescent love relationship was a clear invitation to her father to side with her against her mother. She probably took her father's remarks to mean an acceptance of this coalition offer. Then came her mother's telephone call on Monday, as a counter-attack: "You got sick not because I didn't let you do what you wanted, but because you were a compulsive overachiever." This was followed by her mood swing that same Monday. Her inviting her father to lunch on Wednesday represents an attempt on her part to win, at least covertly, the support her father hadn't the courage to give her openly.

Her father's volte-face during their lunch must have been unbearable and led to her binging and vomiting on Wednesday evening. However, the therapist disagreed with the patient on one point: her interpretation of her parents' relationship. From his experience in working with families like hers, he knows that the patient often regards her father as a nice but weak man, just as Anna does. In reality, however, he is passive with his wife only where the children and the running of the household are concerned. When matters affect him directly, he exhibits a strong stubborn streak. For example, he may not allow his wife to have any say at all on his comings and goings outside the family sphere. The therapist knows that Anna's father also is extremely busy with work and that he often manages to work on Sundays, despite his wife's objections. Therefore, what's at play here is not so much a matter of weakness as the fact that he doesn't want to get involved in going against his wife for his daughter's sake. At the same time, he is more than willing and able to do so on his own behalf.

During this part of the session, the therapist also asks the patient to discuss his interpretations of the therapeutic sequence. Once the session is over, the therapist carefully notes all the topics they have talked about and the patient's most significant verbal and nonverbal responses.

To summarize, the therapist follows this simple scheme at each session:

In the pre-session, the therapist reviews his notes from the previous session because the topics discussed in that session are potential starting points for the therapeutic sequence.

The beginning of the session lasts anywhere from 5-10 minutes and consists of discussing a topic of the patient's choice, selected either spontaneously or in response to a general question like "How's it going?" or "How are you doing?" The difference in the patient's behavior during the previous session and the beginning of the new session represents both the ending point of the therapeutic sequence and the week's mood balance.

The middle part of the session is dedicated to an account or report of the past week's events. It consists of a series of questions and answers. By judiciously selecting a few key events and tying them together, the therapist may succeed in establishing the middle part of the sequence and also invite the patient to speculate on the concealed part of the sequence.

The last part of the session is reserved for the therapist's interpretation of the events. The therapist discusses with the patient his own reconstruction of the therapeutic sequence, carefully observing her reactions. If he has been unable to reconstruct the therapeutic sequence successfully, the therapist can use this time to discuss and comment on the patient's story, delve into the past, or do something else, just as long as he stays within the terms of the therapeutic contract.

After the session, the therapist jots down everything that was discussed, the patient's reactions to his remarks, and his own impressions of the session.

POTENTIAL PROBLEM AREAS

The Rationale Behind the Approach

One may wonder why explicitly discussing the therapeutic sequence with the patient is considered the main intervention in the session. First of all, it should be noted that this stage of the session is the only one where the therapist makes it clear that he is discussing his own point of view, based on his experience. Furthermore, by taking this approach, the therapist not only reinterprets the meaning of the patient's experiences but also suggests different behavioral responses that she might try.

In the example, at the start of the session Anna explains her depression in terms of the fact that the therapist has prodded her to talk about herself and her past. This statement carries the implicit message that the therapist must change tactics. But in his reconstruction of the sequence, the therapist attributes Anna's mood to how she used the information he gave her in the previous session in her interactions with her family and the family's subsequent reactions. Her use of the therapist's question to attempt to divide her parents and draw her father over to her side has produced the opposite effect.

If he deems it appropriate, the therapist can suggest alternative courses of behavior for the patient and try to predict her family's reaction to them. The predictions serve as an indirect test of his underlying hypothesis. Naturally, the therapist makes no move to convince the patient of the correctness of his predictions because he realizes they are largely shots in the dark. Therefore, at most, he can only suggest an approach for the patient to take when dealing with her parents and others; on the basis of their reactions, he may then be able to ascertain the validity of his predictions.

We have already noted how the therapist will be unable to carry out this step if he has not satisfactorily reconstructed the therapeutic sequence. In such instances, he can proceed with the session as he thinks fit, as long as he abides by the spirit of the therapeutic contract. There are, however, things that he must never do. For example, he must never make the therapeutic relationship the focus of the therapy, nor should he comment on the patient's behavior toward him during the session unless he can tie it into a wider context that includes the members of her family.

In the example, the therapist does not explain Anna's depression in terms of what he said or in terms of the beginning of therapy. Furthermore, under no circumstance would he remark, for example, that she uses her symptoms to try to control him, which is what she does with others. Such an approach invariably would create dependency problems in the patient toward the therapist, or unnecessarily prolong the length of treatment. This kind of strategy implicitly assigns an intrinsic value to the therapy irrespective of the patient's relationships outside therapy.

The Termination of Therapy

Treatment can continue as long as the therapist is able to suggest alternatives to the patient's way of interacting with her family, and as long as the patient obtains results with these new behavioral tactics. For example, when the patient begins to show signs of improvement, she often becomes increasingly involved in extrafamilial relationships. The patient may be presented with new opportunities that easily conflict with the time-consuming demands of therapy. Since the therapy explicitly takes second place to all other relationships, if the latter are in any way compromised or jeopardized by the continuation of the therapy, it should be terminated or suspended. On the other hand, as in other types of therapy, treatment should also be suspended if the patient experiences a relapse of her condition. In some cases, the patient suffers a relapse immediately after a deadline for terminating therapy has been agreed upon. Even in this situation, therapy is nevertheless terminated as originally scheduled.

Let us consider an example. Grazia, years old, entered therapy after 8 years of anorexia. After 19 sessions, she and the therapist agreed on terminating therapy at the end of the following month, after an additional 5 sessions. Two sessions later, Grazia was obviously much thinner and reported she was nervous because her menses were overdue. Naturally, the therapist doesn't immediately point out the connection between her worsened state and the termination of therapy. Instead, he asks her about her family's reaction to the news that the therapy will soon be over. As a result of this query, he learns that 2 days after being told about the termination of the therapy, Grazia's mother decides to make a pilgrimage to the Sanctuary of the Virgin Mary in Monte Berico to pray for her daughter's recovery. By this time, Grazia had already regained her normal weight and had been menstruating for several months, following 8 years of amenorrhea. The patient said she felt hurt by her mother's action. The therapist had warned her of the possibility of this kind of reaction from her mother, but Grazia was apparently still too attached to her mother not to let her mother's pilgrimage affect her.

The therapist, then asked Grazia about her father who, according to her, had always suffered the most because of her illness. Grazia replied that her father had made no comment and acted as if he hadn't understood, but that he had accompanied his wife on her pilgrimage. In the next couple of days, he had finally started some construction work around the house about which he'd been dragging his feet and which his wife had been wanting him to do for a long time, but which Grazia had totally opposed. After hearing all this, the therapist was able to show Grazia that her relapse was not due to the fact that therapy was about to terminate but, rather, to her family's reaction to the news.

The Expertise of the Therapist

The therapist constantly uses the six-stage model for the anorexic family as a guide in helping him to reconstruct the therapeutic sequence. Nonetheless, his success in using this model hinges on the skills and ability he has developed during his years of clinical experience with this type of family, be it in work involving the entire family, the parents, or individual members of the family.

Furthermore, the therapist must be skilled at accurately detecting even the slightest changes in the patient's mood. At the beginning of every session, the therapist is faced with the task of reconstructing the therapeutic sequence by first searching for evidence of changes, usually slight, in the patient's mood from the previous session. The therapist probably would benefit from specialized training in verbal and nonverbal communication, which is woefully lacking in most therapy training. Such training might possibly include practice in analyzing videotaped sessions. One useful method for analyzing the differences in narrative verbal styles has been suggested by Labov and Fanshel (2). With regard to nonverbal communication, Ekman and Friesen (1) have worked out a particularly effective model for analyzing facial expressions.

CONCLUDING COMMENTS

According to the six-stage model for the anorectic process in the family, the patient is involved in a family "game" with which she can't cope. In this game, everyone is supposed to hide and disguise his or her emotions, feelings, and intentions. In the individual treatment, the therapist avoids disguising his emotions and intentions, providing for the patient an experience of a different kind of relationship. Nonetheless, the therapeutic relationship is always only considered as an instrumental one; the therapist focuses how his statements and suggestions affect the patient's behavior inside the family, and how the ongoing family game affects her attitude toward him. This technical arrangement seems to be a useful tool in order to shorten the length of the therapy itself. According to the therapeutic contract, the patient is led to modify her behavior inside the family in order to test the therapist's hypotheses and interpretations about the ongoing family game.

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